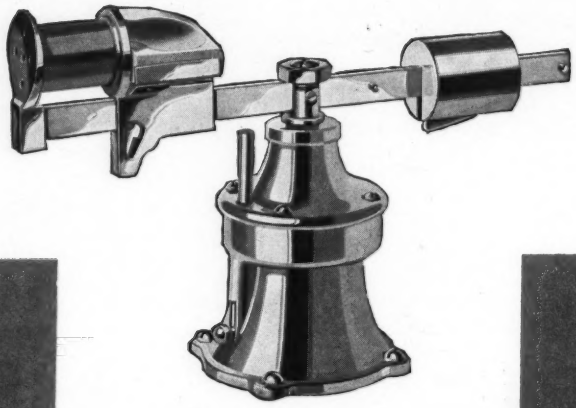

Oral
Hygiene



PERFECTION

CENTRIFUGAL CASTING MACHINE

EVERY STEP in the production of an inlay, cast crown, bridge or denture, from wax pattern to the final polish, is important. Equally important, but simplest of all is CASTING when this is done with the Perfection Casting Machine.

The spring is wound, producing a dependable, uniform amount of casting force; the gold is melted; the arm is released, and the molten metal flies into the mold, reproducing the finest details of the wax pattern.

PERFECTION CASTING MACHINE $25.00

With Akers' flasks and counterweight for large castings..... $28.50

IT'S AS SIMPLE AS ABC TO CAST WITH PERFECTION

THE *Cleveland* DENTAL MANUFACTURING CO.

CLEVELAND, OHIO U.S.A.

VOL. 27, NO. 12

Oral Hygiene

DECEMBER
1937

EDITORIAL OFFICE: 708 Church Street, Evanston, Ill.; PUBLICATION OFFICE: 1005 Liberty Avenue, Pittsburgh, Pa.; Merwin B. Massol, Publisher; W. E. Craig, D.D.S., Associate; R. C. Ketterer, Publication Manager. NEW YORK: 18 East 48th Street; Stuart M. Stanley, Eastern Manager. CHICAGO: 870 Peoples Gas Building; John J. Downes, Western Manager. ST. LOUIS: Syndicate Trust Building; A. D. McKinney, Southern Manager. SAN FRANCISCO: 155 Montgomery Street, LOS ANGELES: 318 West 9th Street; Don Harway, Pacific Coast Manager.

WARDEN JOHNSTON
A Friend of Dentistry

by F. VANCE SIMONTON, D.D.S.

A FRIEND OF DENTISTRY was honored recently by a testimonial dinner at the Palace Hotel in San Francisco on the occasion of publication of his book, PRISON LIFE IS DIFFERENT.[1]

The author is James A. Johnston, formerly Warden of Folsom and San Quentin Penitentiaries, and now head of the federal prison at Alcatraz.

Recognition of Johnston's many contributions was shown by the attendance at the banquet of representative members of the professions and arts, of business and public life.

One of the speakers, Rabbi Coffee put it aptly when he said, "Prison life *is* different because of Warden Johnston."

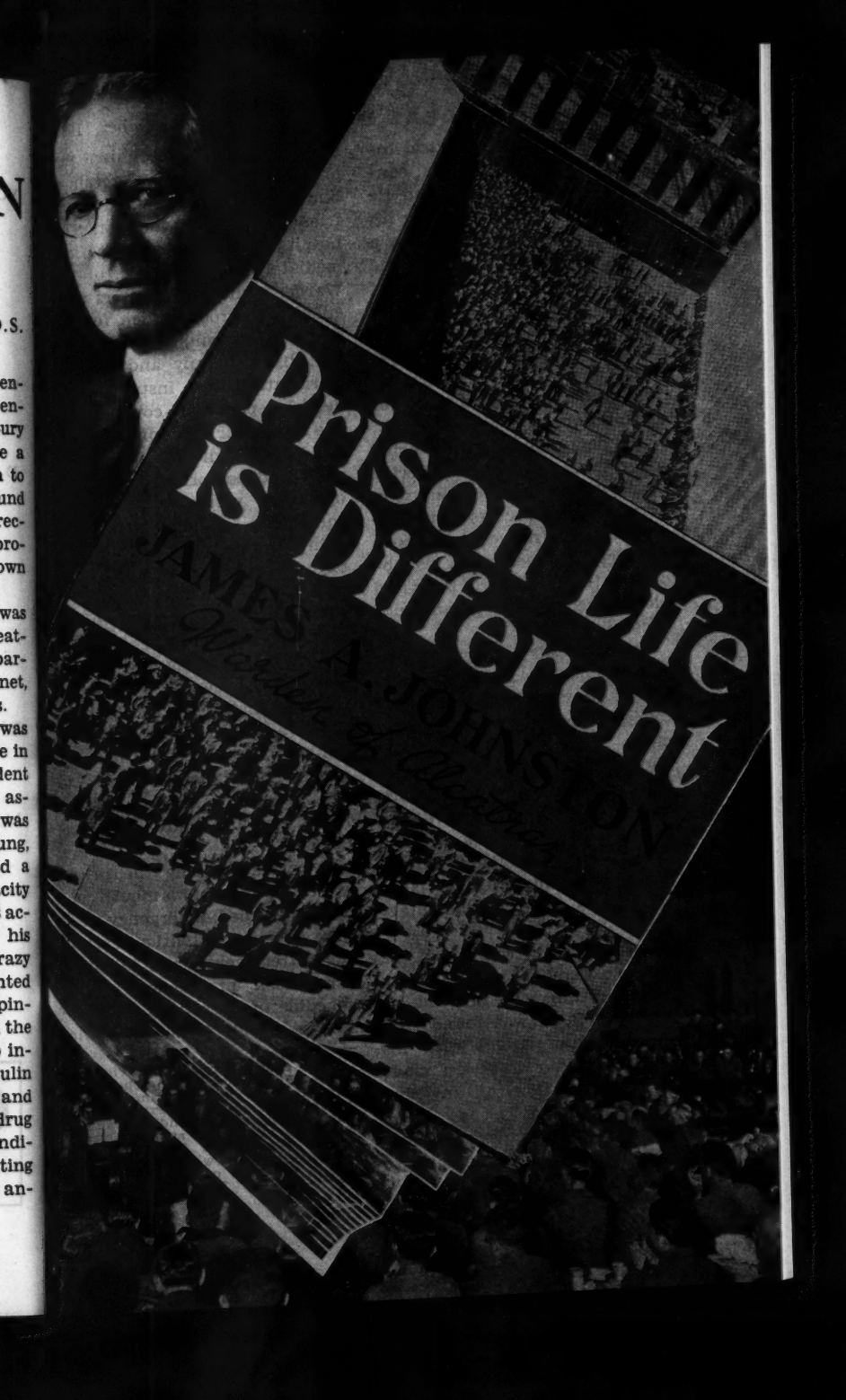
Warden Johnston made medical and dental care the first step in his correctional program. The importance of dentistry in penology is discussed in the chapter titled, "Battered and Bruised Humanity in Need of Repair."[1] The author also describes the prison dental department and tells of the work of the California Stomatological Research Group in Pyorrhea.

As a result of initiative by Mr. Johnston, the first full time dentist was appointed for San Quentin nearly a quarter of a century ago. The dentist was to give a third of his time each month to Folsom, but before he got around to it, the Board of Prison Directors had been persuaded to provide that institution with its own dentist.

The office in San Quentin was a corner in the physician's treatment room, furnished with a barber chair, a homemade cabinet, and a handful of instruments.

Shortly after the dentist was appointed a change was made in the medical staff, the resident physician resigned and his assistant, Doctor L. L. Stanley was put in charge. Stanley was young, forceful, progressive. He had a talent for surgery and a capacity for quick decision and prompt action. He took everything in his stride—sprinting over to "Crazy Alley," to rout out a demented convict; patching up a jute spinner who had been mangled in the mill; macerating pancreas to inject in a diabetic (before insulin was to be had); interviewing and writing up case histories of drug addicts; selecting jobs for handicapped workers; experimenting with gland extracts and new an-

[1] Johnston, J. A.: Prison Life Is Different, Boston, Houghton Mifflin Company, 1937.


Prison Life
is Different
JAMES A. JOHNSTON

esthetics; designing surgical instruments; writing articles; conferring with the parole board. He has since become famous for his surgery, his research, and as a writer, radio commentator, and traveller.

Association with him was a privilege and a comfort. He was entirely reasonable about everything, energetically cooperative, and devoid of any instinct for exploitation.

The dental department started to grow. It spread into Doctor Stanley's private office, and soon devices for all sectors of the digestive tract from centrifuges to articulators appeared on his laboratory table. Plaster of Paris and blood smears and sputum cups decorated the shelves.

On Wednesday afternoons the dental office was moved out into the hallway and the treatment room became a surgery department. There Doctor Stanley did appendectomies, herniotomies, hemorrhoidectomies. The dentist was extended the same privileges as the visiting surgeons, and had to endure considerable "kidding" on his versatility with the polar extremities of the alimentary canal.

Doctor Stanley was one of the first to use spinal anesthesia and, like everything else he used, he improved it. It was found that reclining the patient with his head low after injection made possible operations on anything below the thorax.

Shortly after Stanley's appointment, Warden Johnston came to San Quentin[2]. He recognized the physician's ability and retained him. They have remained warm friends throughout the years. The hospital dental department immediately felt the drive of the Warden's interest. Quarters were enlarged; a roof garden for tuberculous patients was constructed; hydrotherapy and modern sterilization were installed. The dental department covered half the lower floor space of one of the buildings assigned to the medical work and comprised two single operating rooms with modern equipment, including x-ray machine and a nitrous oxide and oxygen apparatus, a third room with three homemade chairs for prophylactic treatments, and a four man laboratory.

With the coming of Warden Johnston, his own social orientation dominated the prison. The repair and rehabilitation of the inmates was the hub around which everything was made to turn. The fact that jobs existed for officers and guards was incidental.

Everyone entering the prison was examined and his mouth condition recorded. Emergency cases were given first attention; extractions, treatments, and full dentures took precedence in the schedule of operations. For certain cases all forms of service

[2] In the illustration accompanying this article Warden James A. Johnston is shown together with a reproduction from the jacket of his book "Prison Life is Different" showing a Sunday scene in a portion of the Yard at San Quentin Prison (Courtesy of Houghton-Mifflin Company) and a view of the general mess hall at the same prison.

were rendered; that is, for "life timers," those with a health handicap and those who had rendered meritorious service. These cases were subject to approval by the warden. Others were allowed to pay the costs of crown and bridgework in so far as the staff could find time for such services—there was at that time a population of two thousand and "fish" were coming in at the rate of a hundred a month.

Convicts As Patients

What kind of patients are convicts to work on? What is the atmosphere of a prison? A book like Warden Johnston's helps one to know as well as books on economics and sociology. A young dentist in 1913 wouldn't see much below the surface even though well disposed. Lincoln Steffans used to say, "I don't want my son to be good, I want him to be intelligent." Steffans' autobiography helps one to understand too the reason behind the reason for prisons. Only when one knows these things can he comprehend what prisoners are like and measure their merit and their misery.

Human nature in those days was apprehended principally as material for anecdotes. Many incidents were humorous, for humor, as Professor Radin says, is a manifestation of suffering. The oppressed races have been the wittiest. The boys relished fun even at their own expense.

For instance the waiter in the officers' mess removes the breakfast dishes with a treasure—a nice fat cigar peeping out from under the edge of a carelessly thrown napkin. Cigars are contraband. But alas, it turns out to be only a butt. The waiter makes no mention of the practical joke at lunch or dinner. Next morning the breakfast plate presents a delicious breakfast steak, covered with a crisp napkin. The steak turns out to be a butt also.

Crossing the yard to the office, old Mr. C— once a noted attorney, sings out, "Just saw an engineer going into your office, Doc."—"An engineer?" "Yes. He's going to survey your acher's."

Another attorney, once a candidate for governor, sent up for embezzling an estate, says he believes he suffered more the first night he was incarcerated than most men would in years. He is a picture of chronic melancholy, heartbroken. But men differ. Outside the office window a voice says, "Gee, I'm glad to get back here. You don't get lamb curry and rice at the 'city and county' like they make it here."

Nor is it a matter of education. The most cultivated prisoners may take it hardest or easiest. A world famous composer, committed recently, is busy teaching a class, writing a book, composing music; one piece he is calling appropriately "stir" (slang for prison) music. He has kept his morals and his friends expect him to carry on without any detriment when he is released.

Old black Tom is a character. He has a tooth extracted. The next day he comes briskly across

the yard. Tom has a wide orbit of locomotion; he is the most obvious moving object in any field of vision, consequently the groaning and the lugubrious expression as he comes into the office fail to deceive.

His suffering is accepted, "No, glycothymolene won't help. Your condition is too serious. Two days in the hospital." Tom gets fed up with two days in bed and the hospital chores between times. But he still wants that glycothymolene. Instead he gets something "much stronger," he is told. "Must handle it very carefully—explosive. Spit out every drop after rinsing your mouth—highly poisonous." The druggist fills the prescription, "Agua Distillate, flavored with Valerian Bromide," labeled with skull and crossbones. Tom is happy, carries it about as if it were a bomb. Every morning he rinses and spits, spits until he is nearly dehydrated, and the boys who are in on the joke get a huge kick out of it.

A former political boss of San Francisco, Mr. R., is given an honorary degree one slack Saturday afternoon. He is made "dental attorney" in recognition of his interest and the amount of service he has endured. He is draped with a cape of blotting paper. The oration is delivered by Judge S., once dean of a correspondence law school—a brilliant mind, whose writings may be found in bound volumes with those of Woodrow Wilson. Brilliant, but a little too voluble, he gets in R's hair, as everyone knows he will. R. responds with appropriate but caustic wit. Drinks—lemon juice—are served all round.

A week later the Warden drops a casual remark. The "old man" knows everything. His secretary at Alcatraz made the same remark the other day.

Courage? A condemned man refuses treatment for an "ulcerated" tooth, won't let anyone touch it. A couple of weeks later on the scaffold he nonchalantly spits a cigarette out of his mouth and inclines his head for the black cap. A circus performer, hero of the "slide for life," hanging by his teeth from a rubber bit as he slides down a wire from the center pole, cringes in the dental chair. An imperturbable Chinaman has his teeth dug out without an anesthetic and never bats an eye.

Lee, the hospital barber, his bald head an experimental field for Doctor Stanley's skin grafts, scoffs at pain. A bur is run into the pulp of a cuspid tooth as in the old days when teeth were devitalized for bridges, so they would never give any trouble. A twisted broach removes the "nerve" in front of a dozen witnesses. Lee never flinches.

Lee sends a box he has made of inlaid woods to his mother for Christmas. She walks five miles through a drizzle to get it and is prepared to walk another five miles home, accepts carfare under protest. "Lee was a wonderful son," she says, "Never a harsh word." He is a recidivist for murder.

Warden Johnston, of course, got closer to the lives of the men than anyone else. He tells many significant stories in his book; tells them with dignity and restraint, realizing as he often says, that it is just as incumbent on a warden to respect the confidences of his wards as for a physician to respect those of his patient.

Certain famous cases, however, such as those of Jake Oppenheimer, the Human Hyena; "Bluebeard Watson" accused of murdering nine wives; Bill O'Connor, the "Battling Bandit"; and Jess Lord, moral degenerate with one eye, one arm, and one leg, could be presented without any abuse of confidence as they had already been discussed freely in the public press.

For many readers the most touching story in the book is the simply told tale "A Negro Convict Who was a Good Sport."

California Research Group

The California Stomatological Research Group was born at San Quentin. Conditions favorable for its birth were present. There was a progressive Warden who was ready to further objectives in which he had confidence. He saw merit in the Stomatological Research project as did Lafayette Mandel and E. V. McCullom later. The Warden's method was to aid without interfering, to foster without smothering, to get behind those immediately engaged in a piece of work and not to block or frustrate them. These are indeed rare virtues.

The dental profession is of course familiar with the work of the Group from the technical point of view but is not familiar with the human interest side of the story.

Doctor Stanley, then as always, was human interest personified. He worked with everyone in the Group, heard their needs, and issued orders. Tables were provided for diet squads; men were found to serve on them. As experiments touched on his own field, he undertook them and carried them through promptly and carefully. He advised with each branch of science involved. He secured what is difficult to get in this country—biopsy and post mortem material.

The Group grew, volunteers joined, small funds acquired made it possible to enlist a graduate worker with training in fundamental science, and the endeavor expanded beyond its clinical beginning. A series of papers were presented at the meeting of the Stomatological section of the American Medical Association in San Francisco in 1921.

Doctor H. Jerome Allen of Santa Barbara was in attendance at the meeting. He told President Pritchett of the Carnegie Corporation of a group research project in dentistry that was under way. The idea clicked with President Pritchett. Probably Doctor Gies or some of his confreres had sown the seed. A grant of $85,000 was made to continue the work.

At one time thirty persons were engaged simultaneously in the

work. A serious treatment of the sociological aspect of such group research is beyond the scope of this article, as is any attempt to evaluate the group method. Space permits only a few recollections.

Convicts As Subjects

Doctor Martha Jones sits in Doctor Stanley's office at San Quentin. A diet experiment has been planned. It is to comprise fifteen subjects.

Who to get for the "stroke"? Doctor Stanley has it. "Bluebeard Watson," husband and murderer of nine or more wives. He was the man on Doctor Clark's mineral metabolism experiment squad, who refused a dish of contraband ice cream rather than break his pledge to Clark. "Old Faithful" was sent for. He came, an unctuous personality, rubbing his hands and bowing. Doctor Stanley introduces him to Martha, explains and finally admonishes, "Now remember, Watson, don't murder the lady before she completes her experiments."

Years later Watson still thinks of the pyorrhea work. He has a theory. Since the disease starts between the tooth and gum, why not set in strips of metal along the crevices so the trouble can't start? Also why not cold foods since cooking is concomitant with civilization.

One of the convicts (Mr. W.), who acted as clerk, would send out the "duckets" for various prisoners who presented cases appropriate for the studies. These tickets carried the numbers of the prisoners and were passes to come to the dental office. It was noticed that W. would write the five figures following the names without referring to the files and, on being asked how he could remember them all, he said it was much less trouble to remember them than it was to look them up. His phenomenal memory, it was found, had served him previously as head of a narcotic ring in Chicago.

There were many great disappointments too; that is the nature and the lure of research.

On one occasion it was extremely important to get post mortem material from an execution. All arrangements were made and the young dentist engaged to assist in the project had his instructions. He slipped up on the assignment and his excuse was that Doctor Stanley felt so badly over the executions he didn't have the heart to remind him.

It was explained to the young dentist that post mortem material was much more important than Doctor Stanley's feelings or, as Anita Loos would say, "Holding hands is very nice but a diamond bracelet lasts forever."

The young dentist is now a practicing physician. Let us hope he is still as sympathetic.

Much work has been done through the years as a voluntary continuation of research by scientists who worked with the Group. Doctor Jones, as everyone in the profession knows, has made valuable contributions. Professor Morgan has written many important articles. Doctor Herman

Becks is the heir of the Group. Former members are scattered about the world, from Africa to Persia, to Hawaii. Johnston mentions many of the personnel in his book.

Becomes a Banker

When Mr. Johnston gave up prison work for a time to become a banker in San Francisco, he was tendered a dinner by the professions and the university scientists. He was presented with a book; each page of which contained an appreciative sentiment from some prominent member of the scientific world who had been acquainted with him

At the recent banquet, his friends were many and prominent; representative members of the medical, dental, legal and engineering professions, leaders from the religious world, the world of arts, of music, of letters, officials, statesmen, and business men. Senator Hiram Johnson wired congratulations from Washington, Mayor Angelo Rossi, from a sick bed in San Francisco.

Doctor A. H. Gianninni, President of the United Artists Moving Picture Corporation, came by plane from Hollywood. When he spoke he drew attention to the fact that the crowd which filled the ballroom was unique—as not a person there was hoping for any of the favors that a warden might be able to bestow.

Doctor J. C. Geiger, Director of Public Health of San Francisco, spoke of his service to medicine, Doctor Guy S. Millberry of his service to dentistry. Former Secretary of the Navy, Justice Curtis D. Wilbur, commented on his social contributions. Representatives of the Commanding Generals Officers of the Army and Marine Corps and of the Admiral's office of the Twelfth District Naval department made appropriate remarks. Canon William Wright of Grace cathedral spoke for the bishop and paid his compliments. The columnist John Barry dwelt on the humanities, and Luther Meyers, Literary Editor of the *Call*, referred to the Lincolnian simplicity of Johnston's book. Former Governor C. C. Young and former Speaker of the House, A. A. Rosenshine, spoke in a personal vein, and Doctor Stanley told of a meeting of the kangaroo court—how, he said, concerning a candidate for parole, "I think, Warden, that he is just a bad boy," and the Warden replied, "No, Doctor, I believe, rather, that he just isn't a good boy."

Warden Johnston is still in his prime, energetic, intelligent, creative, forward thinking, a slim grey haired man, mild mannered, quiet, steady eyed. He looks exactly the opposite to the popular idea of a warden. He has a depth of understanding, unusual in one so competent in officialdom. His arteries have never hardened; his ears are open and his eyes clear.

With John Barry we congratulate him on his present book and look forward to his next.

450 *Sutter Street*
San Francisco

You Can Spare TWO DOLLARS

by JOHN W. COOKE, D.M.D.

THIS IS A FINE time of year to be reminded of misfortunes which are not one's own. Especially, if you happen to be a dentist. Because, from September to January, any year, is a financial headache; that is, it is more of a headache than any other time, which is quite a headache, relatively speaking.

I enjoy the independence which comes from paying my bills. I gain a pronounced stimulation from walking with my head up, fearing no man, which is an intellectual escape comparable to thumbing my nose at the world. But when things gang up on me I become uncertain and afraid. The insurance companies, with some justice, expect a share of my income; the bank, which admits to a substantial interest in my real estate, sends me printed notices of payments due; taxes abound; the children need shoes and new clothes; and my daughter's tuition must be paid. Add to this the not uncommon circumstance that patients are vacation minded, financially, as well as actually. And nothing would probably make my worries seem insignificant except to be told by the Relief Commission of the American Dental Association that there are people in the world less fortunate than I, who sometimes, far more frequently than I suspect, require help which they themselves are unable to supply. Truly this is a swell time of year to be reminded of someone else's troubles.

This matter of helping someone else is nothing new to dentists. As a matter of fact, the unfortunate, the ignorant, and the defrauders are common property in dental practice everywhere. Association with people possessing these characteristics is probably a good thing; were it not for this, the practice of dentistry would be too easy, too profitable, and too pleasant. Something ought to be said about it, in school, possibly, or one's certificate of license to practice should contain a requirement that a dentist devote half his life to sweet charity. By some such method, frequent disappointments might be avoided, and dentists might become accustomed to expecting what most of them actually receive, instead of starting in professional life with the profound conviction that the world is a wide open oyster. Unfortunately, however, that is not the way things are.


A.D.A.
RELIEF
FUND

Things with dentists are about like this. By and large, we are a hard working group, comparable, if you please, in industry and training to members of other learned professions. We assume responsibilities on a level with what we think our position is, and sometimes we are wrong. Some of us experience greater disappointments than others. This is probably due to the fact that trouble is not particular about its friends, and misfortune, of one type or another, is never a predictable calamity. From old age, from foolishness, from disease, from fire, flood, pestilence, and lingering death, good Lord deliver us! Most of these crises are unpredictable; most of the emergencies which crush ambition, stop inspiration, and cloud the prospect of life's horizon are things which we just didn't see coming. Each of us may some day be urgently in need of help. Each of us may be profoundly thankful that there is such a thing as organized dentistry.

To protect the interests of dentists, and to advance the cause of dentistry, there is the American Dental Association. Like most good organizations, it tries to do more than it can; consequently, its structure is frequently ineffective and top heavy. That is not the fault of the organization nor of its ideals. By and large, it is doing a good job. It would do a better job, if you would help it.

One of the important activities of the American Dental Association is the Relief Commission. It is, as its name implies, a bureau empowered to disburse funds to certified and deserving applicants. Whoever wrote the rules of this game was a smart man, for he knew that dentists are credulous and human, and he wanted to be sure that funds supplied for relief were employed for relief. Consequently, by a somewhat intricate system, your contributions for the Christmas seals are guarded zealously against waste and improper use.

Last year, 14,500 dentists gave $21,000 for Christmas seals; the funds to be administered for purposes of dental relief. This amounts to approximately $1.50 per donor. Individual contributions varied from 10c to $25.00. The smallest total for any state was $9.00 and the largest total from any state was $4,450. State Dental Societies, which obey the rules of the game, are entitled to have refunded for their own relief funds, one half of their contribution towards the Christmas seals. And these respective funds are from time to time swelled by donations from the smaller component societies. Approximately 90 per cent of the State Societies come under this category.

Maybe you have never heard of a dentist who needed relief. Or have you? Then possibly you don't associate with the right kind of dentists. There are plenty of dentists, poor fellows, who hate being obliged to accept relief as much as the relief commission enjoys being able to give it. And that is quite a lot. During the past year,

54 relief grants were made to 47 applicants; there were 21 renewal grants; and there were 9 cases where the funds were forwarded to widows of dentists. This took place in 18 states, and the current relief payments totalled somewhere in the neighborhood of $8,000 a year. I think that is a fine record—something to be proud of.

But no record is final, if it is worth its salt. It should furnish an inspiration for greater accomplishments. In fact, an increase in funds is essential, since the number of certified applicants has increased over 35 per cent during the past three years.

If you have a passion for detail, there is one angle of this problem which may have occurred to you, if you have paid any attention to the figures. The gross income for relief during the past year has been approximately $20,000. The gross expenditures for relief have been about $8,000, as the interest only is available for relief. The Relief Commission is trying to build up a fund whose principle shall remain inviolate; the income being adequate to take care of certified cases

Trouble Unannounced

Can you predict what will happen tomorrow? If you can, you're good. You're so good that you shouldn't be practicing dentistry. Maybe someone did predict the floods, but he didn't shout loud enough about it, because nothing was done. No one called the turn on these emergencies. But the emergency did arise and, thank God, dentistry is taking care of its own.

If you are a dentist, then you have many friends. That is, you have friends if you have any practice at all. Furthermore, possibly closer to you than some friends, you know a few dentists very well indeed. One, or possibly more of the friends, if your experience is typical, has encountered misfortune. He may have been unwise, he may have been unlucky; no matter what the cause, the result is the same. Those unpredictables again: disabling and expensive illness; unexpected financial reverses with consequent discouragement; disasters of nature; old age, than which there is no prospect more disheartening. What do these calamities mean? You know what they mean. They carry in their wake poverty, pauperism, worries, the inability to face firmly the sunshine of tomorrow's morning, and lingering but certain death. One of these friends has doubtless come to you in his extremity. He was at the end of his rope or he wouldn't have come. And if you had the money, if you had what he needed, you didn't loan it to him on a note, you didn't send him to a bank to exercise his credit. You gave it to him freely, openly, charitably, and generously as a friend.

But suppose you didn't have it? Suppose there was no place for him to turn. Suppose it wasn't your friend. It might have been

you. Remember the often repeated quotation:

"There, but for the grace of God, go I."

Think it over, and use your judgment.

Last year you, and several thousand others, averaged $1.50 per person in contributing toward dental relief by the Relief Commission of the American Dental Association. If your business is better this year, and it may very well be, you can do better than this now. That is, if you are one of the ones who averaged a dollar and a half last year. If you gave nothing last year, and you may without discredit belong in that class, now is a good time to start. There aren't as many willing takers in this world as some people would have us believe. But the place is chock-full of willing, anxious givers, who need only to be told of the cause, to dig down with enthusiasm, and to add to the already substantial total, that those less fortunate may be aided and tided over in their hour of extremity.

This may be a poor time of year to talk about it. Any time is a poor time if you're not the kind of person who wants to help. And any time is a good time if you're the kind of person I think you are, who is looking for a chance to help somebody else. You ought to know the sensation to which I am referring. You're a dentist, aren't you? You've been a push-over most of your professional life for all kinds of calls, some of them good, some of them bad.

Well, here's a good one. Remember the Christmas Seals.

60 *Charlesgate West*
Boston, Massachusetts.

NATIONAL POSTER CONTEST ANNOUNCED

To STIMULATE interest in and enthusiasm for preventive dentistry and dental health the American Dental Association is sponsoring a national poster contest for all school children above the third grade. All state societies, and through them, the component societies are being asked to organize these poster contests and publicize the rules governing them. Prize winning posters of the children who compete in the contests conducted by the component societies will be brought together and displayed at a national contest to be held in Saint Louis, when the Association meets there in October, 1938.

These posters designed and executed by the children are supposed to, in so far as possible, represent original ideas based on one or more phases of preventive dentistry or dental health, such as proper diet, exercise for the teeth and gums, mouth cleanliness, and preventive operative dentistry.

Frank L. Hardy, straight shooting dentist of Midland, Michigan, made headlines in daily papers and *Time* magazine when he leaned out of his office window one morning and fired across the street at two bandits escaping after holding up the Midland Chemical State Savings Bank and wounding its president and cashier. Five out of his six shots took effect on the bandits who were trying to flee in their high powered car. The bewildered bandits jumped out of their car, shot and seriously wounded an innocent truck driver supposed to be the author of the mysterious shots. One bandit fell dead; the other ran on and was captured later. Doctor Hardy, whose precise shooting made him a hero, graduated from the University of Michigan in 1912; is 47; served two years in the Army, one of them in France; belongs to a group of Midland business men deputized to protect citizens from bandits; and likes to hunt deer.

Recognition For DENTISTRY

by MILLARD D. GIBBS, D.D.S.

ANOTHER AVENUE OF recognition for dentistry is indicated by the current interest in the subject of identifying persons through dental records. The ramifications of this service are unlimited. It opens up an opportunity for every dentist to contribute his share in this work in his daily record keeping, and it offers one more reason why dentistry should be given full recognition on every health program.

The dental profession has made rapid progress during the past two decades and, endowed with a knowledge supported by results from the practical application of scientific discoveries, has the right to seek recognition in all departments of health and its related programs, and to demand such recognition in the interest of the public welfare.

With great progress having been made regarding dental pathology and its relationship to systemic disorders, it is nothing short of criminal neglect for dental diseases to be ignored in the general physical examination

In several articles published it has been my pleasure to bring to the attention of the dental profession the idea of a dental examination in conjunction with the medical requirements for applicants and policy holders of life, health, and accident insurance. The reaction to this effort from insurance companies has been of a favorable nature, which prompts me to believe that a united demand by the dental profession for such recognition would accomplish much with beneficial results for persons concerned. Not only life insurance companies, but particularly accident insurance companies, should have complete dental records of all policy holders, for these companies are often forced into court and settlements are delayed because means of a reliable nature are not available for positive identification.

In cases of accidental death it often happens that faces, bodies, and limbs are mutilated beyond recognition, but with complete dental records such confusion would be, in a vast majority of instances, almost impossible. Dental records in private files have, in numerous instances, proved their worth beyond any reasonable doubt in establishing correct identity.

Records, however, to be complete, must deal with more than missing teeth and dental restora-

tions. They must have roentgen rays, not only of the teeth, but of the maxilla, for herein lies much of the significance of the dental record. Anatomical development varies, and osseous abnormalities occur in different persons. Such peculiarities are more pronounced in the skull and should prove one of the best means of identification. Identification from dental records in the field of insurance certainly presents a question worthy of much consideration.

Mining companies, railroads, and all industries offering hazardous occupations surely can be made to see the advisability of such a method as a means of identification.

Insurance companies are to a pronounced degree progressive, and in keeping with such a tendency, they should not be long in recognizing the advantages to them of accurate dental records once the idea is called to their attention. Disasters of every character affect them, and delay in establishing identity adds not only expense, but interferes sometimes indefinitely by delaying settlement of claims, which is out of line with the general company policy of early settlement of all claims.

Police files, if they were bolstered up by complete dental records, would aid materially in solving much crime, and if all criminals, when captured, received dental care, many of them would leave penal institutions far better equipped mentally and physically to avoid further crimes.

Another door of opportunity has really been opened for dentistry to enter. Are we going to close it? Or, shall we enter it a united body, as a profession really interested in doing things worth while pertaining to dental service in the interest of the public welfare?

For five years it has been my pleasure to try and gain recognition for dentistry by life, health and accident insurance companies, but until the meeting of the American Dental Association in Atlantic City (July, 1937) I had failed to make the progress I had anticipated. Now, however, the Insurance Committee has the matter before it and has promised to give the question due consideration. Individual encouragement has come from many sources, but no definite action has materialized. Now that the Insurance Committee has taken the question under advisement, I feel sure definite steps will be taken for the consummation of such an important recognition.

When complete realization is arrived at by all dentists and physicians that dentistry is no longer a system of mechanical ideas alone, but is a definite department of health service to which the public is entitled, then, will we, as a profession, render our complete service to humanity. Dentistry must fight for its rights to receive all recognition to which it can lay just claim, and until we begin to make such an effort we must continue to have forced upon us the unjust stigma of an inferiority complex.

OFF THE RECORD
VIEWS OF DENTAL LIFE

Have you a picture of dentists in action? Not an ordinary, posed snapshot but some unique or unusual glimpse of dental life—a candid shot of a dental meeting, a dentist in a novel rôle, or a newsworthy dental scene.

If you have had a lucky shot, why not share it with ORAL HYGIENE readers? Please send your photographs, *with postage enclosed* for possible return, to the Editor, ORAL HYGIENE, 708 Church Street, Evanston, Illinois. We pay $3.00, on publication, for each photograph accepted.

Dentistry is prepared to render much service in various fields as yet untouched. Dental records as a means of identification have great possibilities. Dental service to insurance companies and all industrial concerns has unlimited possibilities.

Delay is often disastrous. So it is my sincere hope that the American Dental Association will take immediate steps to give momentum to this splendid idea. The recognition to which dentistry is justly entitled should not be dealt with lightly. Let us start agitating these questions, becoming interested to the point of doing things that will ultimately result in our goal being reached.

Were insurance companies to adopt the idea of dental records for identification purposes, they would have from such records an opportunity to determine the presence or absence of health hazards from the point of view of dental infection, and by insisting that unhealthy mouths be given proper dental care, would build better risks in each age classification. Thousands of physicians annually examine applicants and policy holders for insurance companies. Why not dental examinations, since infection is responsible for 85 per cent of all deaths from disease?

The World War gave plenty of evidence of the crying need for accurate means of identification. Had complete dental records of all enlisted men been in the files of the war and navy departments of all belligerent countries it is doubtful if a monument would have been erected to the "Unknown Soldier."

Hot Springs, Arkansas

MEDICAL MEN *Seek Changes in* HEALTH CARE

AS AN AFTERMATH of the interest aroused by the comprehensive study of medical care in this country published this year by the American Foundation[1] a committee of medical men representing 430 prominent physicians and surgeons announced recently that they had formulated principles and proposals anent changes in medical care. These men are of the opinion that "medicine must be mobile not static if medical men are to act as expert advisers." Their long range objective is a national public health policy directed toward all groups of the population.

This group of medical men is described as self-appointed by Doctor John P. Peters, Professor of Medicine at Yale University, secretary of the committee. They are speaking only for themselves and not for the Foundation or any other organization. Among the members of the Committee of Physicians are: Russell L. Cecil, of the New York Hospital; Hugh Cabot, consulting surgeon, Mayo Clinic; George R. Minot, co-recipient of the 1934 Nobel Prize in medicine, Harvard University; John H. Stokes, University of Pennsylvania School of Medicine; and Milton C. Winternitz, Professor of Pathology, Yale University School of Medicine.

The principles signed by the 430 medical men and presented to medical organizations throughout the country for consideration are:

1. That the health of the people is a direct concern of the government.
2. That a national public health policy directed toward all groups of the population should be formulated.
3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their solution.
4. That in the provision of adequate medical care for the population four agencies are concerned: voluntary agencies, local, state, and federal governments.

Proposals necessary for the realization of these principles, in the opinion of the medical group, are: that the risk of illness be minimized by prevention; that public funds be furnished to provide adequate medical care for the medically indigent; for the support of medical education and for studies, investigations, and procedures for raising the standards of medical practice; for medical research; for hospitals that serve the medically indigent; for laboratory, diagnostic, and consultative services; that public health services, federal, state, and local be extended by evolutionary process; and that there be a functional consolidation of all federal health and medical activities, pref-

(*Continued on page* 1644)

[1]Medicine Speaks; Dentistry is Silent, ORAL HYGIENE 27:1032 (August) 1937. Editorial, Dentistry Was Ignored, ORAL HYGIENE 27:1068 (August) 1937.

FRIENDS OF CHILDREN MEET

WHO SHOULD CARRY on the dental health education program? The dentist, the teacher, the dental hygienist or the school nurse?

This topic brought out a lively discussion at the open forum session during the Fourth Annual Meeting of the Good Teeth Council for Children, Inc., held in Chicago. The keynote of this discussion was struck at the dinner of the Board of Directors of the Council when F. C. Cady, D.D.S., dental consultant to the State Health Authorities, United States Public Health Service, talked on THE PHILOSOPHY OF DENTAL HEALTH EDUCATION. Morris Fishbein, M. D. editor of the *Journal of the American Medical Association* was the introductory speaker. Guy S. Millberry, D.D.S., Dean of the College of Dentistry, University of California, and Chairman of the Council Board of Directors presided at both meetings.

State dental directors, school dentists, deans of four dental colleges, health education directors, and teachers from 22 states participated in the discussion.

Dentists who enter the school room to talk to children about mouth hygiene are trespassing in the field of the educator so they must be prepared to cope with the teacher and talk on the grade level of the pupils, according to C. Carroll Smith, D.D.S., dental director of Peoria, Illinois, Public Schools.

Other pertinent points emphasized by Doctor Smith were:

Dentists must acquire the teacher's attitude and the teacher's language.

Too often the dentist's English is poor which the teacher resents.

Dental health teaching material must be graded to fit the needs of the special grade to which it is to be presented.

Perfect illustrations enrich the teaching material and help to build a dental consciousness.

Ask the teacher to assist you in preparing your material.

Contributing to the open forum session, Doctor Cady said, "In my opinion if you have a well grounded health educational program in your schools there will be a minimum amount of follow-up needed to obtain the maximum number of corrections. It is essential to follow up the children in those homes where there is no support given to the schools in any of the health measures. Dental follow-up is no different from the follow-up of any of the health procedures to obtain corrections of any defect. In many places it is successfully handled by the public health nurse attached to the health department. In other places it is the responsibility of the school nurse. In still

other places it is done by the teacher. It is essential that the school health program be as complete and thorough as possible to eliminate the necessity of so much follow-up work in the home."

Believing that the teacher is the logical person to teach mouth hygiene, R. C. Dalgleish, D.D.S., dental director, Utah State Board of Health, urged that the teacher training institutions be persuaded to include oral hygiene in the course of study.

Don Gudakunst, D.D.S., director of school health, Detroit Department of Health, expressed the opinion that the free clinic is obviously not the complete answer to the school dental problem. Contrary to the opinion expressed by several at the meeting, Doctor Gudakunst said that the dental health teaching in schools should be carried on by persons who specialize in this field as a result of their laboratory work or professional training. The curriculum of teacher-training is too crowded to inject a course in oral hygiene.

J. M. Wisan, D.D.S., of the New Jersey Council on Mouth Hygiene, and lecturer at New York University, condemned the "canned speeches" too frequently resorted to by dental health lecturers. He claimed that no person can prepare a single series of dental health talks to meet a state-wide or nation-wide situation.

Miss Florence Hale, Editor of *The Grade Teacher*, and a Council director, in summarizing the discussion spoke from the educator's point of view: "In introducing the subject of dental health into the schools, the ideal situation would be to have this work become a part of the health education program carried out by the regular teacher in the particular school. However, at the present time, considering the teacher's already too-great teaching load, it is probably impractical, since it would mean that instruction in a highly technical subject would have to be given by a person who at best could have only a superficial knowledge of the whole field of dental health.

"Teachers are not intentionally non-cooperative nor are they unappreciative of the efforts and desire of the dental profession to promote mouth hygiene, but their daily and monthly calendars are crowded by routine subjects and 'special holiday' assemblies.

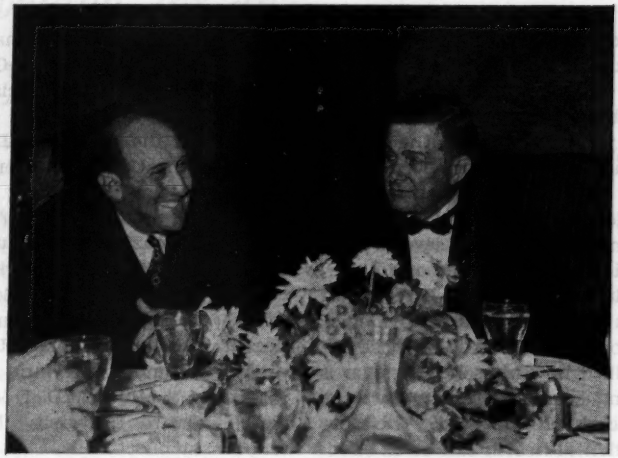
"Therefore, it seems best for the moment that dental hygiene teaching be carried out to a great extent by regularly trained persons," concluded Miss Hale.

Dean F. C. Elliott of the Texas Dental College, Houston, Texas, described the material his school is preparing to be distributed among outside agencies as a contribution in the public health educational field.

C. W. Camalier, D.D.S., president of the American Dental Association, talked on the need of standardization of dental health education material and Lon W. Morrey, D.D.S., Supervisor, Bureau of Public Relations, Ameri-

The fourth annual meeting of the Good Teeth Council for Children, held in Chicago: (Left to right) Leo A. Gerlach, D.D.S., Dental Director, Division of School Hygiene, Milwaukee Health Department; D. L. Houser, D.D.S., Chief, Bureau of Dental Hygiene, Ohio State Department of Health; Ernest A. Branch, D.D.S., Director, Division of Oral Hygiene, North Carolina State Board of Health; and Milton G. Walls, D.D.S., Chairman, Advisory Board, Minnesota State Dental Society.

Left to right: F. C. Cady, D.D.S., Dental Consultant to the State Health Authorities, U.S. Public Health Service; Guy S. Millberry, D.D.S., Dean, College of Dentistry, University of California and Chairman, Board of Directors, Good Teeth Council for Children, Inc.; Mrs. L. C. Snowden, President, Woman's Auxiliary, Texas State Dental Society; Mr. E. H. Hatton; and with back to camera, Mrs. Guy S. Millberry.



Morris Fishbein, M.D., Editor, The Journal of the American Medical Association; F. C. Cady, D.D.S.

With back to reader: E. C. Geiger, D.D.S., Director, Bureau of Dental Health, Florida State Board of Health; (left to right) Leroy M. S. Miner, Dean, Harvard University Dental School; J. M. Wisan, D.D.S., of New Jersey Council on Mouth Hygiene; C. J. Speas, Director, Dental Hygiene, Vermont State Department of Public Health; F. C. Elliott, D.D.S., Dean, Texas Dental College; J. F. Owen, D.D.S., Director, Bureau of Dental Health, Commonwealth of Kentucky Department of Health.

can Dental Association, emphasized the value of simple, well-worded authentic material for the use of classroom teachers.

The guests at the meeting had the privilege of seeing the several visual education projects which the Council has developed and which are being used to supplement the program of several state and city dental directors.

Henry E. Childs, Director of Visual Education, Providence, Rhode Island Public Schools, described how his school system is using sound motion pictures to teach health. He said, "The story of dental health can be as effective as the teachings of the best trained dental education instructor."

During the week, a health institute was held for the Council staff. The institute faculty consisted of Doctor Millberry, Doctor Morrey, and Doctor John Sundwall, Professor of Public Health and Director, Division of Hygiene and Public Health, University of Michigan.

The Board of Directors of the Council are:

Guy S. Millberry, D.D.S., Chairman, University of California College of Dentistry, San Francisco, California

Arthur D. Black, M.D., D.D.S., Northwestern University Dental School, Chicago, Illinois

Florence Hale, L.H.D., *The Grade Teacher* magazine, 425 Fourth Avenue, New York, New York

E. V. McCollum, Ph.D., Sc.D., School of Hygiene and Public Health, The Johns Hopkins University, Baltimore, Maryland

Leroy M. S. Miner, M.D., D.M.D., Sc.D., Harvard University, Boston, Massachusetts

Lon W. Morrey, D.D.S., American Dental Association, Chicago, Illinois

Frank C. Neff, M.D., School of Medicine, University of Kansas, Kansas City, Kansas

John T. O'Rourke, D.D.S. School of Dentistry, University of Louisville, Louisville, Kentucky

John Sundwall, M.D., Division of Hygiene and Public Health, University of Michigan, Ann Arbor

---

MEDICAL MEN SEEK CHANGES IN HEALTH CARE

(*Continued from page* 1639)

erably under a separate department.

Commenting editorially on the signing of these principles and proposals by promient medical men, the *Journal of the American Medical Association*[2] regrets "such careless participation in propaganda," and points out to the "unthinking endorsers," the danger of federal subsidies for medical schools, research and hospitals.

---

[2]Editorial, The American Foundation Proposals for Medical Care, J. A. M. A. 109:1280 (October 16) 1937.

Looking for an EXCUSE

by M. GILBERT, D.D.S.

DURING RECENT YEARS when my business was bad, it was always a comfort for me to be able to find an excuse: There was a depression; it was too hot or too cold for the patients to come; it was either too close to Christmas or too soon after. Yes, I was never at a loss for excuses then. Those were the good old days.

Just now it happens not to be too hot nor too cold; it is neither before nor after Christmas and, according to all reliable statistics, there is prosperity in the country, but I find even now a critical condition existing in many dental offices.

Dentists are sitting idle in their offices from 9 a. m. to 9 p. m. daily and a few extra hours for good measure on Sundays. With all the talk of prosperity they are still worrying and unable to meet their bills. Every day seems like a year and paradoxically every first with its bills seems to rush in like it was just yesterday.

On one side we see even now a great percentage of dentists sitting in their offices nervously waiting for patients; on the other side we see an ocean of people with toothless, disfigured, and diseased mouths crying for dentistry but unable to pay for it.

Some of our leaders seem to put the blame on the dentists for their plight. They say the reason that the dentists are not making enough is because they are not business men. First of all, the dentists are not supposed to be business men. If they were, they would not have become professional men. Second, no amount of persuasion will help when the people have no money to pay for dentistry.

Let us see why the business men have the advantage over us. To begin with they send out smooth, persuasive salesmen, who make use of unscrupulous tactics to get rid of radios, washing machines, or what nots. The salesmen, after getting the first payment, never see their victims again. The merchants, thereafter, use all kinds of ways and means to collect a few dollars a week. They employ shrewd collectors, use threatening legal letters and then collect their bills. (I, for one, would not want to practice dentistry under such conditions.)

Let us look and see what we actually find in our offices when the patients are forced by a few sleepless nights to come to the dentist. They only want the offending tooth removed. When one

talks them into a much needed service, they usually show up a few times and quit. Most of the work is left unfinished. The reason is that the ones with no jobs naturally cannot pay and the ones who have jobs are not making enough to pay for dentistry. Another reason is that those slick salesmen are ahead of us and have already tied them up from head to foot for a million and one things. Another drawback for the ones who make a fair salary and who could afford to pay for dentistry is the fact that they are uncertain about their jobs and do not want to part with their savings.

I want to bring up one instance apropos of good salesmanship, and I am sure that all dentists catering to the poor class meet with thousands of such cases . . .

A young woman, 28, came to my office with her upper centrals and laterals broken down and badly abscessed. I convinced her she should have a stationary bridge and a temporary partial denture, while the gums were healing and the payments accumulating. She was to pay $60.00 at a rate of $5.00 per week. I found out after a few visits that she was a stenographer making $22.00 per week. She looked emaciated, underweight, and anemic. She told me that she used to weigh 140 pounds and now weighs 92 pounds. Her husband has a severe case of arthritis and has not been working for the past 3 years. They have one boy, 8, who also is malnourished and anemic. I advised her to drink a bottle of milk daily to gain weight, and she told me that she could not afford to spend 8 cents a day to buy milk for her child or herself as she had to meet all living expenses for the three, including clothing, medical bills for her boy and now the payments for me. Thereafter, whenever she gave me a few dollars I felt like a criminal taking away milk from an anemic mother and child. Unfortunately, I needed the few dollars.

I believe it is absolutely wrong, unjust, and misleading to blame the dentists for their plight. We are serving in a difficult profession and we are all trying to be up-to-date, skilfull, and do the best we know how for our patients. It is about time to stop knocking the dentists and look for the real cause of our troubles.

Old Age Assistance

I want now to take up another matter. The government is trying to furnish teeth to the old persons through the old age assistance. They are referring some of the patients to private practice. The old people, with a few remaining elongated teeth that disfigure their faces and interfere with mastication, and those who have been toothless for many years are all extremely anxious to get teeth. They hope that teeth will correct their indigestion. They want them to aid in talking and to help them look presentable again. To them every day is like a century. They first wait about 6 to 8 months until they are put on

the list, and then they wait several months until they get a slip permitting them to go to the dentist for an estimate. Then they wait and wait endlessly. The old persons get a few crumbs from the government, but have no teeth with which to grind them. The dentists have the teeth, but lack the crumbs. It seems as if the authorities are experimenting and watching the race to see who will die first, the patients or the dentists.

The big industrialists and bankers know what is good for them. They combine and fight for the preservation of their undivided surpluses. Because we dentists are spending most of our time lately arguing about the merits and demerits of the latest obtundents, we will soon have more obtundents in our offices than patients.

We who have dedicated our lives to our profession, who know the importance of dentistry, including the ill effects of neglect, are guilty of indifference and refusal to see the misery and hear the cries of the people who are begging for teeth. Let us stop thinking for a short time about obtundents and divert our attention and energies to the unfortunate, the old, the feeble, with a view to trying to find some way to help them. Let us be instrumental in helping to make their last few years more comfortable, easier, and more pleasant.

There is no greater compensation for a dentist than to watch the change in the face and eyes of an old person, especially a woman, who has just put in a new denture after being toothless for several years. You can see her eyes beam with happiness, as she thinks that she now looks almost as good as when she was 18, and has new hope and fantastic ideas of starting life all over again.

The public at large as well as the government officials are all looking to us to make a move to do something, but we seem to evade the issue. We seem to hide our heads under the sand with the illusion that the present conditions will blow over.

It is about time that organized dentistry should wake up and do something for the millions of old and young who need teeth and at the same time help the members of the profession who need the work badly. Let them work out a plan to offer to the President whereby the millions needing dentistry can get it now while they are still alive, and they should see to it that the supervision should be by dentists and not laymen, and that the work should be done in private dental offices.

1919 *Broadway*
New York, New York

A MEDICAL STUDENT
Looks at Dentistry

by GABRIEL E. CECI

IN THE COURSE of our medical education we quite often encounter members and future members of the dental profession.

In the good-natured bandying of words that is always an inevitable result of such association we chide each other with our evident lack of knowledge about our allied profession.

A limited experience in the clinic has been enough to convince me that what is said in a jesting manner is only too true. There is a gross lack of cooperation between the medical and dental curricula in the schools and between the professions on the outside. In justice to my dental-minded colleagues I must say that the lack of cooperation is almost entirely on the physician's side. Let me exclude, however, those physicians who have interned in hospitals side by side with one or more dental internes, before I draw heavy fire.

Regardless of what criticism I may draw upon myself I will insist that the schools are primarily at fault for the existing condition.

In the course of our studies we are given one or two brief lectures on the teeth. Does some prominent dentist, some authority on the subject, give us these lectures? No! It is a physician who knows as little about teeth as the students do and who has probably forgotten a great deal more. Result: one badly bungled lecture, classed as unimportant by the medical student. We retain a vague idea of names, a hazy conception of time of eruption, and an altogether distorted view of the pathological factors in the formation and eruption of teeth.

Superficial Work

How often, in giving a patient a so-called "thorough" examination, does the physician slide perfunctorily about the patient's mouth with a tongue blade, note casually several dark spots on the teeth, and write on the chart "teeth—O.K." or "teeth fair: few cavities?" Turn then to the dental service sheet on the same chart and note the difference. "Chronic, suppurative gingivitis; three badly infected teeth to be extracted under general anesthesia; four teeth badly decayed; x-ray for pulp or periapical involvement; request medical consultation as to advisability of general anesthesia."

Perhaps, as some may argue, this is strictly outside the physician's field just as diagnosing a

bodily ailment is without the dentist's scope. Granting that it is, and I doubt it, why can't physicians be big enough to note on the charts, "Refer to dental clinic for thorough mouth examination," or, "Request dental consultation to rule out focus of infection"?

Are we so big and so all-knowing that, if a thing comes within our scope and knowledge, it's worthy of annotation and if it doesn't it is a mere unimportant trifle? Let us deflate a little! We are all too puffed up with our own importance!

After all, the dentist is a specialist in a particular branch of medicine, he should no more be considered a mechanic than the orthopedist. Granted, it takes a good knowledge, a thorough knowledge in fact, of mechanics for these men to follow their profession. Let us not grudge them their due, rather let us be big enough to take off our hats to our colleagues, the great specialists in a new branch of medicine, the dentists!

Let us forget that the two professions are distinct, are separate. Rather let us remember that they are correlated and interdependent. Let the schools of medicine and dentistry recognize this and let them teach the subject as such: Dentistry, a branch of medicine; the dentist, a specialist in the field of oral surgery, pathology, and mechanics!

964 *North Eleventh Street*
Milwaukee, Wisconsin

DENTAL MEETING DATES

College of Dental and Oral Surgery of New York, Class of 1921, informal luncheon and class reunion, Hotel Pennsylvania, New York City, December 10, at noon.

Dental Protective Association of the United States, annual meeting, Palmer House, Chicago, December 20, at 4 p. m.

Dallas midwinter dental clinic, eleventh annual meeting, Adolphus Hotel, Dallas, Texas, January 17-19.

North St. Louis District Dental Society, midwinter meeting, St. Louis, Missouri, January 26-27.

International College of Dentists, United States Section, next annual meeting, Stevens Hotel, Chicago, February 13.

The District of Columbia Dental Society will again act as host to the Five State Post Graduate Clinic, Mayflower Hotel, Washington, D. C. March 6-9, 1938.

Thos. P. Hinman midwinter clinic, Biltmore Hotel, Atlanta, Georgia, March 14-15.

American Dental Society of Europe, Stockholm, Sweden, August 1-3, 1938.

Editorial Comment

GIVE ME THE LIBERTY TO KNOW, TO UTTER, AND TO ARGUE FREELY ACCORDING TO MY CONSCIENCE ABOVE ALL LIBERTIES. *John Milton*

RECLAMATION

TWENTY-FIVE YEARS ago James A. Johnston[1] entered California's forbidding Folsom prison as the new warden. Here he found noisome cells, one shower and four zinc bathtubs for a thousand men, inadequate medical facilities, and no dental facilities at all. Warden Johnston set about correcting these conditions. He ventilated the cell blocks; he built a bath house; he began the reclamation of the physical wrecks who were under his charge. "Repairing broken bodies and restoring health paved the way for mental development and moral training"—this became the theme of the new prison administration. Warden Johnston abolished the severe forms of physical punishment without becoming a sentimentalist. He treated all the prisoners alike; he had no favorites. Nevertheless he saw each one as an individual personality with problems, ambitions, potentialities of his own. Warden Johnston individualized personality treatment as carefully as he did medical treatment.

Shortly Warden Johnston went to the larger prison of San Quentin. Here he found a high death rate from tuberculosis. To correct this condition he built an open-air hospital. As a result, deaths from tuberculosis were decreased from ten per thousand to two per thousand. About 65 per cent of the inmates gave histories of venereal disease. The medical department under Doctor L. L. Stanley began to give salvarsan treatments and mercury rubs to the men infected. Drug addicts and psychopaths were numerous among the convicts. With the help of outside medical experts individualized treatment was given for these types in the same way as for the sufferers from other forms of disease.

---

[1]At present the Warden of Alcatraz Federal Prison and author of the recent book Prison Life is Different (Houghton Mifflin Company) from which this material has been taken. Warden Johnston recently returned to work after having recovered from injuries received when he was attacked by a kidnaper and bank robber at Alcatraz in September, 1937.

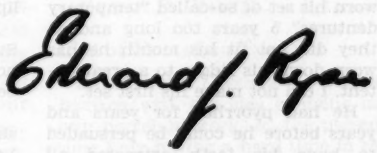
[2]Prisons—An Old Problem Still Needs a Solution. Pathfinder, Page 19, (October 9) 1937.

[3]Hoover, J. E.: The Enemy on Our Soil, New York Herald Trib. Forum (October 4) 1937.

The first dentist at San Quentin was Doctor F. Vance Simonton, the author of the article WARDEN JOHNSTON: A FRIEND OF DENTISTRY in this issue. Doctor Simonton began his work in 1913. Among the average daily prison population of 2384, 95 per cent needed and began to receive dental care. These "battered humans required a lot of repair in order to make them practically or wholly useful." Their dental needs were as great as any other physical handicap that they carried. From these modest beginnings two important dental developments were to come: a complete and thorough dental service, which in 1925 included four dentists and three technicians in San Quentin; and a far-reaching research project on periodontal disease sponsored and financed by the Carnegie Foundation.

In 1921 Doctor Simonton presented to Warden Johnston an ambitious research program. He believed that prisoners living under controlled conditions offered the perfect opportunity to study the causes of periodontal disease. They were always available; their food habits could be observed and controlled; each had a complete medical history. The study in which all types of biological scientists took part was begun. In 1923 the project caught the attention of the Carnegie Foundation and a grant of $85,000 was made by that Foundation to continue the study. Up to that date this was the largest single grant ever made for dental research!

At the present time there are 150,000 persons[2] in prisons and penitentiaries in the United States. The dental needs of this population would require the services of at least 150 dentists. It is doubtful if there are that many dentists so employed. Organizing adequate dental departments in prisons is not "sentimental convict-coddling." There is too much sob-sister stuff regarding convicts as Mr. J. Edgar Hoover has properly stated.[3] The elimination of chronic dental disease and rebuilding of the dental apparatus are important aids in the restoration of physical wrecks. This is not the work of "softies." Few of us want to see pampering in prisons. We are, however, in favor of repairing broken bodies and restoring health, which is the essence of Warden Johnston's penologic philosophy. He has showed dentists that they can be an important factor in such reclamation.



Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply. Material of general interest will be published each month.

Appearance of Dentures

Q.—I have a problem for your department which I hope you can help me solve.

I recently made a full upper and lower set of dentures for a friend of mine.

He can masticate perfectly with them as he has had 6 years experience with a previous vulcanite set. The trouble is that he does not show his upper teeth at all in smiling unless he opens his mouth extremely wide.

The history of the case is as follows:

The patient is a small, slightly built man, 46, weight only 110 pounds, and he has just recovered from a severe case of pneumonia.

He has an extremely long upper lip and his lower lip is thick and protrudes outward.

The upper lip is long and thin and inclines inward. His cheek-bones are rather prominent and his cheeks have a sunken appearance.

The man has been sickly for years and, to make matters worse, he has worn his set of so-called "temporary dentures" 5 years too long and as they did not fit his mouth he has worn down his ridges to a great extent. I did not make his first set.

He had pyorrhea for years and years before he could be persuaded to have his teeth extracted all through fear of the dentist and a habit of procrastination.

As a result of about ten years delayed extraction and of wearing his temporary set 5 years too long, he had rather poor ridges to support his new dentures when he presented himself to me for his impressions.

To make matters worse, he became sick shortly after his impressions were taken so that 2½ months elapsed between the time I ran up his models and the day he received his teeth.

I do not think that this made a difference, however, as his new upper denture fits tightly, and he chews perfectly, despite a poor, flat lower ridge.

Conscious of the fact that he had a very long upper lip and that his original set had settled so that he did not show his upper teeth at all, (which was one of the reasons for making him a new set) I selected longer teeth for his 6 upper anteriors, much longer than the teeth (anterior teeth) on his old set.

On May first I tried the new set-up in his mouth and they looked perfect. He showed slightly more than half the length of his upper anteriors when he smiled and parted his lips.

He lives in a neighboring city. Last Sunday I drove to his home to see how his new teeth looked. He had been wearing them a full week.

Much to my dismay, he did not show his upper anteriors at all when he smiled after all my work of opening the bite 3 millimeters and selecting longer teeth and doing all I could to improve his looks.

Do you believe that his new set of dentures settled as much as this in 2 short weeks or just what is the matter?

I used stone models in his case and there was no apparent change in his mouth despite the two months delay.

My solution of the problem is this: To allow him to wear his new set for the next two months to permit more settling to occur if it is going to do so. Then I shall remake his upper denture using still longer teeth and make just a vulcanite denture. I shall then allow him to wear this vulcanite upper for the balance of the year 1937 and then remake his upper denture with one of the new pink denture bases.

This man is a life-long friend and I certainly want to please him. I have never had such an experience with a prosthetic case before.—J. H. S., New York.

A.—From your description I would judge that the apparent shortening of the upper teeth during the week that your friend wore his new denture was due more to the lengthening of the lip than shrinkage of the jaw. The lip in a case where it has been puckered up by a short bite can easily apparently elongate more than three millimeters in a week's time. Your mistake no doubt was in not opening the bite much more than 3 millimeters, 10 or 12 millimeters is probably more nearly what was needed.

I would suggest that you now fill in the plate with a thickness of modeling compound; possibly 4 or 5 millimeters and also add some buccal and labial contour with base plate wax to help support the lip and take up its slack. Let the man wear it this way for another week, after which add more if his appearance calls for more and if he can accommodate himself to the restored or elongated jaw relation. When you are satisfied that the restoration of jaw relation and facial contour is as it should be, then use one of the new pink denture bases for the upper denture.—V. CLYDE SMEDLEY.

Effect of Chromic Trioxide

Q.—I have been using chromic trioxide as a home treatment in Vincent's infection and other inflammatory conditions of the mouth.

I prescribe one tablespoonful as a mouth rinse for one minute followed by a tablespoonful of peroxide for one minute, three times daily, usually prescribing four to six fluid ounces of a one per cent solution, never any stronger.

Could the use of the drug in this strength over such a short period of time produce an accumulatory poisoning?

A chemist I talked to the other day disapproved of the use of chromic acid for this reason, stating that when it was used commercially great care was needed to protect employees.

I've never observed any reaction since I've been using chromic acid and, as it seems efficient, I don't want to give up the technique unless there is an element of danger in its use as I employ it.—J. W. S., Texas.

A.—Chromic acid is indeed dangerous for patients to use at home because of its effect on the enamel —aside from any systemic effect. —GEORGE R. WARNER.

Use of Porcelain Furnace

Q.—Recently I bought a porcelain furnace, with the idea of doing my own porcelain work. At the present time I am having a hard time in removing the platinum matrix after the final bake. Can you tell me what to use to dissolve the platinum, or is there any acid that will loosen the matrix, so that it won't take me an

hour to dig it out, piece by piece?—H. S., Pennsylvania.

A.—If you will burnish the wrinkles thoroughly out of your platinum matrix and avoid tearing or splinting the platinum, you should have no difficulty in peeling it off readily after the final bake. Platinum is soluble in aqua regia. Porcelain may be etched or dissolved by hydrofluoric acid.—V. CLYDE SMEDLEY.

Cellulitis

Q.—Recently I injected to block the mandibular nerve and removed the pulp from the first molar using a procaine solution which I prepared myself. The root of the tooth was filled and an amalgam restoration placed all while the rubber dam was in place. Next morning the tooth felt fine and was not sore but the jaw could only be opened about half way and was sore and stiff. Two days later the patient had 103 degrees of temperature and still after a week has fluctuating temperature ranging from 99 to 100. Berger says that infections from solution or needle do not manifest themselves before four to eight days. She has no cold or systemic condition that would point to a coincidence. The tooth is sound. I can understand the stiffness of the jaw but not the fever. She has a low resistance, does not eat right, sleep right, and is soft and over weight. There is no swelling about the jaw and no evidence of pus. Her mouth and throat look normal, and there is no pain.—J. E. D., California.

A.—The case described in your letter is puzzling, in fact from your complete and explicit recital of conditions and symptoms, there does not seem to be a plausible explanation of the temperature.

As you say, the trismus is not hard to understand. The mere penetration of the soft tissues by the needle is enough in some cases, to set up a cellulitis and the cellulitis does not have to extend far to involve the periarticular tissues and result in a trismus. However, I have never seen a rise in temperature from an early cellulitis. One would expect a breaking down of tissue—infection—of some extent and demonstrable, to cause a temperature of 103.

We have had two such cases in which an abscess developed in the region anterior to and a little below the anterior pillar of the tonsil. The temperature was up to 103 for about 24 hours before we could locate the focus of infection. However, such an abscess had not had time to develop subsequent to your nerve blocking and before the temperature shot up to 103. So, I am as much at sea about your case as you are.—GEORGE R. WARNER.

Xerostomia

Q.—I have a patient, 40, who complains of a slimy feeling on the left side of her mouth not long after she arises in the morning. This condition did not appear until a lower left second molar was extracted. However, the condition is only on the upper left side.

A complete roentgenogram of her mouth is negative. The patient has a large swelling in the thyroid region that might suggest a goiter, but this diagnosis has never been confirmed. The patient is also a nervous type.

When she expectorates, there doesn't seem to be enough saliva present. The condition seems to get worse as the day goes on and reaches such proportions that the patient becomes nauseated.

She also has a burning sensation on the lower left side where the tooth was extracted, but there doesn't seem

to be any reason for it.

If you could give me any information that might lead to the cause or cure of this condition I should appreciate it very much.—O. A. W., New York.

A.—The case presented is rather baffling. However, after having considered all possible conditions of the mouth as being in causal relation to the xerostomia complained of, a general physical examination would be in order. If you find nothing in the mouth, it becomes a medical rather than a dental case.

According to Prinz & Greenbaum[1] there are 3 principal varieties of this condition, that is why a physician should be consulted:

1. Those cases arising through some psychogenic influence.

2. Those due to senile, idiopathic, or atrophic disturbances of the salivary glands.

3. Those having their origin within the medulla oblongata; in other words, an organic neurosis. —GEORGE R. WARNER.

[1]Prinz & Greenbaum, Diseases of the Mouth and Their Treatment, Philadelphia, Lea & Febiger, 1935.

NOTICE

NOTICE TO ALL dentists in Pennsylvania. An important change in date on the Dental Registration by the Educational Department at Harrisburg.

March 31 has been allotted to Dental Registration so the registration will be due April 1 instead of January 1. There are fourteen groups registered under the Educational Department and to eliminate sending of all notices for January 1 each year, changes have been made making the expiration of the several groups for different months of the year.

DEAR ORAL HYGIENE:

"I do not agree with anything you say, but I will fight to the death for your right to say it."—VOLTAIRE

A School Dentist Says

In response to the article What is a Dental Hygienist?[1] published in ORAL HYGIENE I am writing this letter to you. With fourteen years experience in public health dentistry I feel capable of expressing some ideas as to its practice and also concerning the dental hygienist, its most faithful servant. I, therefore, offer five practical considerations:

1. The dental hygienist is absolutely necessary to the successful operator of public school dental clinics. She must, however, be specially trained in child psychology and must have taken some courses in teaching. She must be a sort of teacher and love children, to be successful in such work. Besides being capable of giving necessary instruction to each patient as he presents himself for prophylaxis she should be able to give classroom talks gauged to the level of the grade and stress one point in oral hygiene per lecture. It has been my experience that complicated lectures telling too much about dental diseases, if illustrated, are only looked upon as entertainment. Children like to get out of class, so these big sessions in the auditorium can be taken at best only as a waste of time.

2. The public health dental hygienist cannot operate in such capacity without adequate, constant dental supervision. Since dental hygiene is the cardinal principle of preventive dentistry, the school dentist is indispensable as the one who charts the course and progress of public health dentistry. And this sort of practice among school children offers the best means now available to bring education and better dental health to the people.

3. Absolutely no advice concerning dental attention should be given by the hygienist. If professional advice must be given, this is the duty of the dentist. Remember that down on Main Street there are many capable dentists whose patients you are examining. Conflicting ideas presented to the patient or the parent just result in the conclusion that someone doesn't know what he is talking about. Then the prestige of the whole dental profession in the community drops a few degrees and that is what hurts most. If you have not got the support of the local dentists and they become antagonistic toward the clinic, you may just as well close the clinic; besides, it is unethical to criticize. We all make mistakes.

An exception to the previous paragraph may be cited here. If there is no cooperation with the local dentists when the clinic is started, this should not be taken as a bad sign because in some localities even the dentists need a shaking up of their minds. If you operate the clinic eth-

[1]Jeffreys, Margaret: What is a Dental Hygienist? ORAL HYGIENE 27:1331 (October) 1937.

ically and teach the children that dentistry is necessary and that good health depends upon it, under normal conditions one may expect the whole-hearted cooperation of the local dentists sooner or later. They will be thankful for the new patients that come to them seeking this kindly help rather than appearing with acute abscesses and the old story, "Gee Doc, I just hated to come here. I hate all dentists. But I just couldn't hold out much longer. Please don't hurt me! Will you?"

4. Operative service should be limited to real indigents and emergency temporary service should be extended to all who need it. When dentistry is done for the poor only, the best materials should be used and the most conscientious service should be rendered if at all, and no charge should be made as good service and small fees are incongruous. Charity is nothing more than charity and it should be done in good faith.

5. Records are necessary but they should not be used as competition between clinics. In the first place they are not standard in all communities. Second, they may be taken as targets for criticism of the good work that is being done. Can't we just be happy in the thought that we are doing a great good and forget that we performed 3000 prophylaxes, extracted 1000 teeth, and so on, and that school district number 23 is lagging away behind?

I have witnessed various instances of efforts to produce a good record, where a continued high percentage of caries and foci of infection were conducive to disappointment. One hygienist announced that she decided to forget about diseased deciduous teeth in her examinations because they may fall out before the next examination and notation would only show a high percentage of foci of infection. Now this is a case of deliberately making a wrong examination and writing lies into the records just to make a good showing.

Another thing that makes records faulty is rapid examination in groups. I would like to tell how an examination should be made but this would require a separate paper. However, the examination should be made by a standardized procedure and not be done differently in one clinic than in another. There is only one way to examine and that is the correct way. This should be done by the school dentist and not by the dental hygienist. Let the hygienist chart and keep your findings for you.

In conclusion, let my observations not be misconstrued as censoring the dental hygienist. The physician finds great help in the assistance of the trained nurse; so also should the doctor of dental surgery accept the dental hygienist.—JAMES A. MATTHEWS, D.D.S., 20 *Bridge Street, Glen Cove, New York.*

What Do You Think?

On October 15, 1937, the United Press reported that fifty Psychiatrists of the Bellevue Hospital in New York City had joined the Professional union of the C. I. O.

October's issue of ORAL HYGIENE contains an enlightening, yet depressing editorial,[2] on the unionization of dental laboratory workers. The editor ventures the opinion that dentistry itself will be unionized, and concludes with, "That day the profession of dentistry dies." I agree with the editorial, but before the burial, let us have a wake.

Some years ago, there was a general feeling among the profession that if the public were made dental conscious the influx of patients would make for a healthier population and for happier dentists. The idea was plausible and sounded good. National commercial organizations who saw in this medium the opportunity of furthering their own products took up the cudgels and

[2]Editorial, Are We Ready for Unionism? ORAL HYGIENE 27:1346 (October) 1937.

with well planned script began the propaganda on a big scale.

Organized dentistry also played a part in this ethical disbursement of truth, but with much less vitality. This lack of vitality was due to the fact that they had no side lines to sell, and as a result thereof lacked the financial backing to put the story before the people in a big way.

The result of all this has not helped the economic status of dentistry, because average dental care is still beyond the reach of the great majority of the American public. As to the so-called refinements of the dental art, the percentage of people able to pay for this service is woefully small.

A perusal of the facts will show, that, economically, dentistry has been ill for a long, long time and what is worse, no one has been able to offer anything approaching a cure. Without becoming too involved, let us examine in a superficial way a few of the pertinent facts that have been responsible to a greater or lesser degree for this dilemma.

First, despite what he thinks, the dentist has little to say in the regulation of his fees, because he is a one horse shay in the middle of a malestrom, with plenty of well planned concerted forces pulling at either end. His fees are determined by commercial pressure from without.

Second, unlike his medical colleague, he is faced with a terrific handicap at the start of his career. The initial cost of starting practice runs well up into four figures. He has no control over the prices of equipment, instruments, supplies, and so on. He has no control over technicians' fees, and he cannot prevent patent holding firms from fixing and controlling prices for certain types of appliances.

Third, he is playing a lone hand against definitely organized business. He is in a good many instances a free-lance salesman who promotes, for organized business, that which they could not sell themselves. As a result, his fees must be on a cost plus basis and, whether he knows it or not, by far the greater part of his fee goes into cost.

Dentists who enjoy large practices where the fees are commensurate with the ability of the patient to pay usually wind up with flat feet, indigestion, and bald heads. They may even talk to themselves, but this is usually not due to a large bank account.

He knows there is something wrong and seems to find passive relief in blaming his woes upon organized dentistry. This is unfair, because the American Dental Association is doing a splendid piece of work. The economic problem is so complex they can hardly be expected to cope with it. They have been the scientific leaders who have brought dentistry to its present professional standing and on this record, they have earned a permanent place in the sun.

Is there a solution to the economic rehabilitation of dentistry?

We could eliminate the commercial laboratories by returning prosthetics to our own offices.

We could eliminate a number of new fangled expensive gadgets.

We could possibly eliminate a number of various and odd things, but this would be moving backward. It might help temporarily, but not even the most elastic imagination could find an answer to the problem from this direction.

Dentistry has outsped all the other professions during the last twenty-five years. Can it be this outburst of speed that has left the public behind? The man who is ahead of his time is usually behind in his rent.

As I see it, our need is for constructive, hard-headed business-like leadership to guide us over the shoals. The leaders must be persons who know the dental angle, and who are pledged to its protection. Where we are to find these types of people is a potent question indeed. It behooves all of us to get down to definite constructive thinking. Unless this sort of

leadership is forthcoming, there will be plenty of practical people who will see in dentistry the opportunity for further remunerative exploitation.

Doctor Ryan in his editorial has sounded a note. It may not be a pleasant one, but it rings true.

The consensus of opinion among dentists seems to be, "Let's have a new deal because it can't be worse." But after all, who dare say that it CAN'T.—S. H. RONKIN, D.D.S., 2100 *Walnut Street, Philadelphia, Pennsylvania.*

The Laboratory Worker

In your October issue of Oral Hygiene[2] your editorial comment sort of struck me. For years I have been a reader of your publications, but rarely did I find the laboratory worker mentioned. All of a sudden you rise up in arms when the downtrodden laboratory worker, who after all is one of the main-stays of the dental profession, wants to become organized in order to obtain for himself and his confreres a little better working conditions and a better financial return for his labors—you start rattling the ghost of the dying profession.

It is a known fact that so far as denture prosthetics work is concerned, the laboratory worker does about 85 per cent of it and gets the least remuneration for his efforts, and the exacting demands of his work are known to border on the unbearable.

Had the dentist and the large laboratory owner, who so successfully up to now, have aborted all previous attempts of the laboratory worker to become organized, increased the pay and the working conditions of the laboratory workers in the same ratio as the quality of work they demanded of these same men, I am quite sure no organizer could ever have interested these men.

But why should the laboratory worker be kept from organizing? Is the dental profession free of organization? Are the large laboratory owners free of organization? Are the dental hygienists free of organization? Are the associated dental supply houses free of organization? I should say not and, as far as I know, they are all quite well organized for their mutual and respective protection and profit. In spite of all that, when the laboratory workers want to do the same thing, up goes the cry that the profession of dentistry is dying. But thanks to the Wagner Labor Relation Act, the employer can no longer successfully interfere with the organizing of the workers and I believe the tables are turning. Instead of the death of the dental profession, it is going to be a better profession, for the simple reason that through better working conditions and increased pay, with shorter hours, the dental laboratory worker will be able to increase his efficiency, his ability, and improve the quality of his work so that, if and when the dentist does his work as well as he demands of the laboratory worker, the general public, although paying more for its dental prosthetic work, will be more than recompensed for the additional outlay in cost.

But why are you apparently so worried that, after the laboratory worker becomes organized, the rest of the dental profession has to follow suit. Let this same profession clean its house and let it live up to the standards it demands of the others. I am positive it never need fear anything from any organization. The dental profession brought us in, treated us like a stepchild, and has kicked us around for so long, that it is really a blot on its escutcheon. Instead of helping us, when after all it will help the profession itself, why—its just like killing the proverbial goose that laid the golden eggs.

But why organize with a labor union, you ask. Well, I give you the case of Southern California Technicians, and I believe the same holds true all over the United States.

About five years ago we organized

a club for the dental technicians in order to secure for its members monthly meetings to encourage exchange of ideas, to have clinics, to further the general education and to improve the general status of the technician. The local dental profession was aware of this association, but instead of helping us, they more or less ignored us and worse yet, in a few instances, held us up to ridicule. Our intentions were neither then nor now such that it would have been necessary to invoke the British Trade Dispute Act of 1927. The only thing left for us to do was to obtain a charter in the American Federation of Labor and they did not seek us, we went to them and we hope with their help to receive what the dental profession should have given us of their own free will and accord.

And I say shame on the dental profession, and honestly I am sorry that it could not see the problem the other way. But rest assured it is not going to be for the worst. It will help the profession not only the laboratory worker but the dentists as well.

Think it over and try if you can see it the other fellow's way, and maybe you can find time to write an editorial in favor of the poor dental laboratory workers. And that day the profession of dentistry is not going to die.—ALPH H. KIRCHEN, *Vice President, Dental Technicians Union Local* 100, 523 *West Sixty-fifth Street, Los Angeles, California.*

I Work For Nothing

I have just finished reading PORTRAITS OF SWINDLERS[3] in the August issue of ORAL HYGIENE and this is its effect on me.

For about eight years I have been a dental assistant and, figuring what such experiences as those cited in the article must cost the average dentist who is unassisted, per year, then I have actually worked for nothing. This dentist hopes to have an assistant some day when he can afford one. Well, I think he can afford one much better right now than he can afford not having one. It is the pennies and dimes, to say nothing of the dollars, here and there, which an intelligent, efficient and loyal assistant can save her employer, which pay her salary. Consequently her daily routine is costing him nothing.

Such persons as the would-be hygienist, the watch swapper, and so on, (and I have encountered them all) would never have gotten by an alert assistant but would have been politely but *firmly* refused. Suppose instead of the minister's wife, which was bad enough, the next patient had been the town gossip, only too ready to believe and *repeat* the worst. How much would that have cost the yearly receipts in patients lost, both actual and prospective? Then, too, patients are not only paying for actual dental work done, but for the treatment which they receive from the moment they enter the reception room door until they leave it. That is also where I am useful. I greet the patient with a smile and if he has made former visits, then I have some small personal remark which makes him feel that he is really welcome and, until I bid him goodby, *after* the dentist does so, I feel responsible for his personal and mental comfort. This is no small task, I assure you, but I know it is a paying one for the dentist, as nothing spreads faster than reports of the treatment the patient receives in his dentist's office. Then too it gives my dentist that extra time for special attention so necessary on that case which must be ready for the next appointment—who must *not* be kept waiting, for of all things *hated,* the foremost, is to be kept waiting.

Figure the time I save my dentist by attending to the operating room between patients, talking to solicitors, salesmen, answering the telephone and soothing sometimes worried patients to whom it is unneces-

[3]Brock. F. W.: Portraits of Swindlers. ORAL HYGIENE 27:1055 (August) 1937.

sary for him to speak, making appointments (and changing them) and so on. Since this saved time allows him to see patients whom the unassisted man could not possibly accommodate, I feel now that I am actually *making* money for my dentist. It is my opinion that an assistant is so important to any dental practice that it never fails to amaze me when I realize how many dentists are without them.—THELMA O'DONNELL, 839 *Maison Blanche Building, New Orleans, Louisiana.*

DENTAL PRACTICE ANALYZED

WITH A VIEW TO determining what effect general business conditions have had on the trend of typical dental practices in the United States, ORAL HYGIENE recently conducted a survey covering the first seven months of 1937. Questionnaires were sent to 3000 dentists selected at random from the ORAL HYGIENE mailing list. An attempt was made in this way to form a picture of general conditions throughout the profession by taking a cross section of different types of practices of varying economic status and in widely divergent locations.

Six hundred and seventeen dentists living in thirty-seven different states answered this questionnaire. The majority of the replies were specific and thoughtful. Among these, 380 dentists or 61.5 per cent reported that the volume of their practices had increased in comparison with the period covered by the last seven months of 1936. Ninety-four, 15 per cent, indicated that there had been no change; while 59 or 9.5 per cent reported decreases in their practices. The remaining 79 dentists gave no definite information on their practices.

As an indication of the upward trend in dental practice it is encouraging to note that 61 per cent is a large proportion of this typical group to report increased incomes. A closer examination of the figures assembled also shows that the average increase of the practices listed in this group was 20.9 per cent, and that an average of only 12.5 per cent decrease was reported by dentists whose incomes showed a falling off during the first seven months of this year.

To simplify the picture of current dental practice we might take the number ten as representative of all the dentists questioned. We find then that these questionnaires show that approximately seven out of ten dentists have improved their incomes; two out of every ten showed no change; and one out of every ten reported a decrease in the volume of practice. Altogether this study forms a satisfying and significant commentary on the upward trend in dentistry which should be encouraging to all dentists.

ANNUAL INDEX

Volume 27, 1937

ARTICLES

EDITORIALS

LETTERS TO DEAR ORAL HYGIENE

Lady: "Is this the Fidelity Insurance Company?"

Clerk: "Yes, madam. What can we do for you?"

Lady: "I want to have my husband's fidelity insured."

O

Doctor: "How is the patient in Room 742?"

Nurse: "He's anxious to get home to his wife."

Doctor: "H-m-m-mm. Still delirious, eh?"

O

Elsie: "Don't you approve of tight skirts?"

Jonathan: "No. I think women should let liquor alone."

O

Stranger: "Excuse me, sir, but weren't you in my class at college?"

Native: "Nope. Never went to college. I learned to drink and loaf right here at home."

O

An intelligent girl is one who knows how to refuse a kiss without being deprived of it.

O

He: "When is your birthday?"

She: "When will it be most convenient for you?"

Janice: "So Lillie threw over that young doctor she was going with!"

Clarice: "Yes, and what do you think? He not only requested her to return his presents, but sent her a bill for forty-seven visits."

O

Friend: "Which of your works of fiction do you consider the best?"

Author: "My last income tax return."

O

Swaying slightly, he halted in front of an enormous stuffed tarpon in a glass case. He stared at it for a minute or two in silence. Then he said: "The fella who caught - hic - that fish is a - hic - liar!"

O

Young Man (moaning): "Oh, doctor, I feel awful. I can't eat. I can't sleep. I can't concentrate on play of any kind, and work is a positive nightmare. What do you prescribe?"

Doctor: "Propose to the girl and get it over with."

O

Professor: "Here you see the skull of a chimpanzee, a very rare specimen. There are only two in the country—one is in the national museum and I have the other."

O

Judge: "Erastus Jackson, you say you have an alibi; do you know what an alibi is?"

Prisoner: "Yassuh, Jedge! All I's got to do is prove I was at church meetin'—where I warn't—instead of bein' at de othah place—where I was."

TINKER INLAY

Tinker Inlay is a medium hard inlay gold for general use in inlays and bridgework. It has all the characteristics which have made the TINKER GOLDS outstanding in the inlay field.

- **A very pleasing color**
- **Easy to cast and finish**
- **Smooth, dense castings**
- **Strong, non-flaking margins**
- **Easily manipulated**

. . . . . and at a price at which you can afford TINKER QUALITY in every inlay and bridge.

$1.80 per dwt. $34.92 per oz.

SPYCO SMELTING AND REFINING CO.

51-57 South 3rd, Street, Minneapolis, Minnesota

Let the Spyco Blue Envelop bring you Prompt and Accurate Returns for your Gold Scrap. Ship thru your dealer or direct.

Pinched HOSE

Collapsed Capillaries Similarly Retard Blood Supply To Teeth

Collapsed capillaries in loose, flabby gums oft impede tooth nutrition. Ipana massage by i stimulating aid in restoration of capillary wall helps provide adequate nourishment. Healt gums give teeth firm anchorage and tend to d courage storage of decaying food particles a other injurious substances.

Glamour and sparkle of bright teeth may b brought out by brushing with IPANA. Fo gentle and effective aid to teeth and gums, re ommend IPANA to your patients. Samples o IPANA for clinical use await your request.

IPANA
TOOTH PASTE

RISTOL-MYERS CO., 19-1 WEST 50th ST., NEW YORK, N.